MSS Registered Dietitian (RD) Job Description

Qualifications: see billing Instructions

 Please note: Some registered dietitians (RD's) call themselves nutritionists, but not all nutritionists are RD's.

Job Description

The MSS Registered Dietitian must be knowledgeable about maternal and infant needs during the maternity cycle, the ability to work with low income families and have the professional skills necessary to integrate nutrition services with the MSS team.

The MSS dietitian's role includes:

Screening:

A brief, in-person evaluation to detect the presence or absence of risk factors associated with high risk pregnancy. Screening should be done at intervals throughout pregnancy and in the postpartum period for both mothers and infants.

Depending on the agency setup, some RD's routinely screen clients for MSS risk criteria while other agencies may designate a specific member of the MSS team to provide the initial MSS pregnancy or post-pregnancy screen. Regardless of the agency process all MSS RD's need to be aware of the MSS/ICM screening process & risk criteria. It is also important to note that if an RD is the only MSS team member providing services, at any point in time ,the RD is required to complete all required screening(s) and basic health messages. Please refer to the First Steps manual and MSS/ICM Billing instructions regarding for more details.

Assessment:

An RD assessment in MSS should have increased emphasis on risk factors associated with poor birth outcomes. Purpose of assessment is to determine the extent or absence of the risk and identify client needs and level of self-care. The nutrition assessment includes but is not limited to :

- **Dietary Intake:** Assess nutrient intake in comparison with recommended nutrient intake for pregnancy, lactation, post-partum, and infancy periods. Evaluate issues influencing intake such as; nausea, vomiting, heartburn, constipation, available resources (finances, housing, transportation) and client beliefs.
- **Anthropometrics:** Assess pre-pregnancy BMI, client knowledge of weight gain recommendations and weight gain in comparison to Institute of Medicines (IOM) guidelines.
- **Biochemical/Clinical** A**ssessment:** Review health history and status, pregnancy risk factors, lab values (hematocrit or hemoglobin) if available, drug nutrient interactions, vitamins, physical activity level, smoking, and substance abuse.
    - **Psychosocial/Environmental:** Evaluate adequacy of food supply, household resources and food management skills. Assess client's stress level, coping skills/strategies, and

beliefs related to food and nutrition. Assess client's goals for work, education, family planning and parenting that might impact infant feeding and finances. Assess impact of family's cultural beliefs on eating, nutrition and parenting.

- **Surveillance** - Check back to assess client's status and if interventions were helpful or if further interventions/support are needed.

RD Interventions:

- Provide medical nutrition therapy to prevent or reduce the impacts of specific risk factors: Pre-pregnancy BMI <18.5 or BMI >30, diabetes, hypertension, multiple gestations, age <17 or > 35, breastfeeding complications, infant health problems/birth defects or infant slow weight gain.

- **Health Education**: Provide information based on client needs and current nutrition standards. Topics should include:
  - Why weight gain is monitored in pregnancy which includes possible risk factors or red flags associated with weight gain outside of Institute of Medicine (IOM) recommendations.
  - Client weight gain recommendations
  - How to eat healthy on a budget and/or with limited resources/skills.
  - How stress impacts food choices/weight and healthy coping skills.
  - Importance of physical activity
  - Birth spacing related to maternal nutrition, weight and infant outcomes.
  - Tobacco use cessation and reducing all second hand smoke exposure

- **Case Management-** Referral linkage and advocacy services for health care needs of mother and infant with primary care provider and other community resources.

- **Care Coordination:**
  - MSS Team Participation:
    - Providing nutrition care consultation to the MSS interdisciplinary team as well as individual members of the team regarding nutritional health care needs of the woman in the pregnancy cycle and her infant.
    - Participate in interdisciplinary team case conferencing, care plan development and revisions
    - Utilize other disciplines knowledge and expertise to assist in problem solving and developing interventions.
    - Include client participation, in care plan development whenever possible.

  - Coordination with Community Providers: At minimum you will need to coordinate with the medical provider and other nutrition providers who are working with the client (e.g. WIC, Hospital RD, ECAP, diabetes educator). This coordination with others health care providers and community resources will enhance accuracy and efficiency for all parties & improve client care.

- **Surveillance** - Check back to assess client's status and if interventions were helpful or if further interventions/support are needed.
- Report any concerns of child abuse/neglect RCW.26.44.30.

Documentation:

The MSS clinical records must include comprehensive RD assessments, clear and concise care plans; nutrition counseling, follow-up to care and progress toward outcomes. Reporting of child abuse/neglect must be documented in the charts as well as any communication and follow up with Child Protective Services.

If some of the RD services are provided by an RD in another program (WIC, Medicaid medical nutrition therapy, Medicaid diabetes program). We still need the RD assessment, intervention, & client follow up in chart to ensure coordination & that MSS clients are receiving minimum interventions based on identified MSS risk factors.

MSS interdisciplinary care plan must include RD identified risk factors & client needs. Refer to the MSS documentation requirements listed in the MSS/ICM billing instructions for more details

Knowledge, Skills and Abilities:

- Knowledge of Nutrition RCW 18.138 & WAC 246-822
- Knowledge, skills and ability to provide maternal infant health nutrition services in the clinic, office, home and community setting to women and their infants during the pregnancy cycle.
- Demonstrates the ability to avoid and/or recognize potentially dangerous situations in a home visit setting, and knows how to take appropriate action.
- Ability to be flexible, manage time, resources, and client caseload
- Knowledge of community resources
- Demonstrate understanding and ability to work with low income clients and their families
- Demonstrate respect and appreciation for diversity (culturally relevant, anti-bias, and multicultural).
- Skills to support health behavior change
- Effective oral and written communication skills
- Ability to form and sustain effective relationships with clients & team members and community health and social service providers
- Ability to manage time, resources, and client caseload
- Demonstrate a willingness and ability to provide consultation and guidance to the MSS Community Health worker

Resources:

- Dietetic Association Evidence Based Library http://www.adaevidencelibrary.com
- Institute of Medicine: http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx
- Parent 123 http://www.parenthelp123.org/
- Women Infant and Children's Supplemental Nutrition (WIC): http://www.doh.wa.gov/cfh/WIC/default.htm and www.walwica.org and www.nal.usda.gov/wicworks
- La Leche League: www.lalecheleague.org